



Social Security Release

I / We hereby authorize the Social Security Office listed below to release information concerning my / our yearly benefits to the Student Financial Aid Office of University of Medicine and Dentistry of New Jersey.

Location of Social Security Office: _____

Street Address _____

City _____ State _____ Zip Code _____

Student's Name (Please Print) _____ Parent's Name (Please Print) _____

University Identification Number (UIN) School _____ Parent's SSN _____

Student's Signature _____ Date _____ Parent's Signature _____ Date _____

STUDENT: COMPLETE ABOVE & RETURN TO THE STUDENT FINANCIAL AID OFFICE

TO: Social Security Office
FROM: UMDNJ Student Financial Aid Office
RE: Yearly Benefits

PLEASE RETURN TO:

Please certify the amount of yearly benefits paid to **all** members of the family receiving assistance under the social security number listed above and return this form to our office. List each individual family member and the amount received for the **previous** calendar year. Thank you.

NAME:

TOTAL AMOUNT RECEIVED:

Signature of Social Security Representative

Name / Title (Please Print)